NC DHHS – NC DMH/DD/SAS
Substance Abuse Comprehensive Outpatient Treatment (SACOT)
Endorsement Check Sheet Instructions

Introduction

Prior to site and service endorsement, business verification must take place. In the process of business verification, the business information presented DMA CIS (Community Intervention Services) application is validated. At that time, the provider organization submits a self study of the core rules (10A NCAC 27G .0201-.0204) verifying that they have met all the requirements therein. (The provider is not required to submit this if nationally accredited, licensed with Division of Health Services Regulation (DHSR) or has had a compliance review from NC Council of Community Programs within the past three years.) The documents created in adherence with the core rules should be utilized as evidence of provider compliance where noted in the check sheet and instructions.

The following set of instructions is to serve as general guidelines to facilitate the review of providers for endorsement. Service definition, core rules (as noted above), staff definitions (10A NCAC 27G .104) and other DHHS communications (e.g. *DMH/DD/SAS Records Management and Documentation Manual*, Communication Bulletins, Implementation Updates, Clinical Coverage Policy 8A, and other publications) should be used to support the reviewer's determination of compliance. In addition, the Business Entity Type Reference document assists to clarify the requirements for different business entities such as corporation, partnerships and limited liability corporations and partnerships. On the endorsement check sheet, there are suggested sources of evidence for locating information that may assist the reviewer in determining compliance with the respective requirements. The items identified are not an exhaustive list of sources, nor must each item named be reviewed. The reviewer examines evidence presented only until the element in question is substantiated as being met by the provider.

Provider Requirements

In this section, the provider is reviewed to ascertain that administrative requirements are met in order for services to be provided. The provision of services is addressed later in this endorsement process. This section is reviewed only during the initial review for business status and does not require further scrutiny unless there is a change in the provider's status that would affect this element.

a. Review identified documents for evidence the provider meets DMH/DD/SAS standards as related to administration responsibilities, financial oversight, clinical services and quality improvement. These standards include, but are not limited to, policies and procedures (contents of which are mandated in 10A NCAC 27G .0201 – Governing Body Policies) and the key documents required by law for the formation of the business entity. (Refer to attachment titled Business Entity Type.)

b.(1). Review documentation that demonstrates provider is a legal US business entity. Documentation should indicate the business entity is currently registered with the local municipality or the office of the NC Secretary of State, that the information registered with the local municipality or the Secretary of State is current, and that there are no dissolution, revocation or revenue suspension findings currently attached to the provider entity. Also review corporate documentation demonstrating registration to operate a business in NC.

Information for corporate entities may be verified on the web site for the Secretary of State. (Refer to key documents section of attachment titled Business Entity Type.)

b.(2). Review the policy and procedure manual. It should contain language indicating intent to have national accreditation within one (1) year of enrollment with DMA. Review DMA enrollment document to verify provider's date of enrollment. Once the provider has been enrolled with DMA for a period of one (1) year, a certification of national accreditation or some other evidence supporting the provider organization's achievement of national accreditation must be produced and validated.

Staffing Requirements

In this section, the reviewer is primarily concerned with the hiring practices of the provider and ensuring that all employees required per the service definition are in place at the time of the clinical interview and are equipped with the evidentiary documentation of education, training and experience for which they were hired. This is important for the clinical integrity of the service. The review of the provision of services is more thoroughly examined in the "Program/Clinical Requirements" section of the endorsement review.

In the desk review, the reviewer is to verify that the provider agency's policies and procedures, as well as other administrative manuals meet the requirements of the service definition. The review of the qualifications of personnel hired will occur later in the endorsement process. Review documentation to verify that provider agency requirements of staff include degrees, licensure and/or certifications that comply with the position as written in the service definition, and are consistent with requirements and responsibilities of their respective job duties. Review job descriptions to determine that the roles and responsibilities identified do not exceed the qualifications of the position. This review ensures that the provider has an understanding of the service definition staffing requirements and has established policies for a program that meet those requirements.

For the clinical interview, review staff employment applications, resumes, licenses, certifications and/or other documentation for evidence that degrees and work experience with the target population the provider will be serving is consistent with the requirements and responsibilities of each position. If **any** staff person hired to meet the staffing requirements of the service definition do not meet the requirements for the position, then the clinical interview does not take place. The clinical interview process is described in Program Requirements.

For the on site review, the endorsing agency verifies documentation reviewed during the desk review and clinical interview (if it has been conducted prior to the on site review). The credentials and qualifications of any additional or ancillary staff hired in the time between the desk review and the on site review are examined.

For the 60 day review, include a review of the consumer record and other items necessary to determine that staff are performing clinical interventions commensurate with their credentials and qualifications as well as within the scope of work the their job descriptions. Review staff schedules, attendance rosters, and caseload assignments and interview staff to ascertain consumer to staff ratios. This review should also include a review of supervision plans, notes and documentation of clinical supervision for all staff. Review supervision plans to ensure that they are individualized and appropriate for the level of education, skill and experience of staff. Review supervision notes, schedules and other supporting documentation that demonstrate on-going supervision consistent with the requirements and responsibilities. Personnel records must demonstrate evidence that all required

training has been acquired by each staff member delivering day treatment services and completed within the specified time frames.

a. Review substance abuse certification or license. In some cases, reviewer may need to verify with the NC Substance Abuse Professional Practice Board to ensure that the certification or license is current.

b. Review personnel files or other documentation of substance licensure or certification and documentation such as staff sign in sheets or logs that required staff are on-site supervising the program. This means that the LCAS or CCS is physically on-site and providing clinical and program supervision a minimum of 90% of the hours of program operation.

c. Review program description, personnel manual and job descriptions. Program description and policy and procedure manuals should have language demonstrating that an individualized supervision plan carried out by an LCAS or CCS is required for QP and AP staff. Review personnel files and supervision plans and documentation, such as supervision logs, that substance abuse supervision requirements are being met. Review supervision plans to ensure that they are individualized, appropriate for the level of education and experience of staff and that supervision is provided by the LCAS or CCS. In addition, review notes, schedule and other supporting documentation that demonstrate on-going supervision by the LCAS or CCS.

d. Review program description and proposed staffing schedule for evidence of consumer to QP ratios. The ratio must be no greater than 10 adult consumers to 1 QP. Review staff schedule and SACOT attendance roster to determine consumer to QP ratio. Group service notes may also be utilized to determine this ratio.

e. Review program description, policy and procedure manuals and personnel manuals to ensure there is language demonstrating that paraprofessionals are required to have the knowledge, skills and abilities required to provide appropriate services for the substance abuse population and age to be served and individualized supervision plans to be carried out by an LCAS or CCS is required for paraprofessional staff. Also review documentation to ensure that paraprofessional staff will not provide services in lieu of on-site provision of services to recipients by a qualified CCS, LCAS or CSAC. Review personnel files and supervision plans that document supervision requirements are met. Review employment application, job descriptions and other documents for high school education or GED and work experience with the substance abuse population. Review supervision plan to ensure the paraprofessional is under the supervision of a LCAS or CCS. Review program schedule, staff rosters and other documentation to ensure paraprofessionals are not providing services in lieu of on-site provision of services to recipients by a qualified CCS, LCAS or CSAC.

f. Review program description for language that demonstrates that consumers have ready access to consultation services when warranted by the presence of symptoms indicating a co-occurring non-substance related Axis I or II disorder. Review personnel manual and job descriptions for language that demonstrates a psychiatrist who meets requirements as specified in 10A NCAC 27G .0104 is available for consultative services. If provider agency contracts for consultative services, review contract ensure consumers have ready access to these services. In addition to the above, review service record to verify consultative services have been made available for consumers when warranted by the presence of symptoms indicating a co-occurring non-substance related Axis I or II disorder.

Service Type/Setting
The elements in this section pertain to the provider's having an understanding of the SACOT service and the service delivery system.

For the desk review, review documentation to verify that provider demonstrates a schedule of operation, locations of service and interventions provided are within the parameters specified by the service definition. This review ensures that the provider has an understanding of the purpose of the service and has established a schedule and a program that meet those requirements.

Items in this section do not apply to the clinical interview.

For the on site review, confirm findings of the desk review.

For the 60 day review, include a review of consumer records and other items necessary to determine that SACOT is being provided to consumers who meet the eligibility requirements, that interventions occur in the licensed facility and that first responder duties are a part of the SACOT provider's responsibility.

a. Review program description for language that demonstrates the SACOT provides a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery. Service emphasizes reduction is use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse, development of social support network and necessary lifestyle changes; educational skills, vocational skills leading to work activity by reducing substance abuse as a barrier to employment, social and interpersonal skills, improved family functioning, the understanding of addictive disease, and the continued commitment to a recovery and maintenance program. Services notes should reflect individual and group activities to address the substance abuse treatment needs of the consumers served by the SACOT based on the goals in the PCP.

b. Review program description and schedule of operation for language that demonstrates services are provided during day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school, and to be part of their family life.

c. Must show evidence of a current 10A NCAC 27G .4500 Substance Abuse Comprehensive Treatment license issued by the Division of Facility Services.

Program/Clinical Requirements
The elements in this section are reviewed as they pertain to service delivery. It is important that consumers are served in accordance with the service definition according to individual needs identified in the PCP in regard to the frequency, intensity and type of therapeutic interventions. Interventions should reflect clinically recognized models.

For the desk review, review documentation to verify that the provider demonstrates a clear understanding of the service definition and the treatment of substance related disorders.

For the clinical interview utilize the questions attached to the current endorsement policy. Specific expectations for the clinical interview are outlined below.

For the on site review, confirm findings of the desk review and the clinical interview.

For the 60 day review, a review of service records should demonstrate compliance with program requirements as specified in each item below. Review to verify that the provider has an understanding of SACOT. Review documentation to determine clinical integrity, coordination other services and supports in delivery of services and documented interventions that indicate adherence to best practice standards.

a. Review program description for language demonstrating the following types of services are included in the SACOT program: individual counseling and support; group counseling and support; family counseling, training or support; biochemical assays to identify recent drug use; strategies for relapse prevention to include community and social support systems in treatment; life skills, Crisis contingency planning; disease management; and treatment support activities that may be adapted or specifically designed for persons with physical disabilities or persons with co-occurring disorder of substance abuse and mental illness or developmental disability. Review the operation schedule for evidence of the above program/clinical requirements. Review service notes to ensure the above services are provided appropriate to the goals in the consumers PCP.

b. Review program description and schedule of operation (proposed for new programs) to demonstrate that the SACOT operates at least 20 hours per week, offers a minimum of 4 hours of scheduled services per day, with availability of services at least 5 days per week with no more than 2 consecutive days without services available. Please note, the 4 hours of service is face-to-face and does not count break times and the no more than 2 consecutive days without service includes holidays and weekends.

c. Review program description for language that demonstrates consumers are in attendance for a minimum of 4 hours per day for any scheduled day of service. Group counseling services must be offered each day the program operates. The 4 hours of service is face-to-face and does not count break times. SACOT may not be billed if a consumer does not receive four hours of **face-to-face** SACOT services. Review consumer attendance and service notes to demonstrate four hours of SACOT services are provided for each day the service is billed.

d. Review the policies and procedures for language that demonstrates the development, monitoring and revising of the consumer's person centered plan is the responsibility of the qualified professionals if the consumer was admitted to SACOT prior to the development of a PCP. Review policy and procedure manuals and job descriptions for language demonstrating the expectation that the Qualified Professional will be responsible for the development, monitoring, revising and updating the PCP. Review the PCP for evidence that the Qualified Professional was the lead in the development of the PCP and the planning meeting for same. Review revisions, updates and service notes for evidence that the Qualified Professional continued the responsibility for leading PCP planning.

e. Review policy and procedure manuals and job descriptions for language demonstrating the expectation that the SACOT service provider will ensure provision of first-responder services for all of the consumers. This includes either face-to-face or telephonically 24/7/365, and have the capacity to respond face-to-face within 2 hours, as well as have access to the crisis plans of consumers. In addition to the above, review crisis plans and service notes for evidence of crisis plans and that the consumer and/or legally responsible person is aware of the crisis response procedure and the phone number to reach the SACOT provider. Review

on-call rotation schedules for evidence that after-hours crisis response is available. Review procedure for crisis plans to be made available to the Qualified Professional on-call. Call crisis number and "mystery shop" to verify access according to requirements.

f. Clinical Interview. Use the questions included in the current endorsement policy for interviews with the staff to determine the provider agency's clinical competency to deliver services. All staff hired to provide SACOT must be interviewed.

Documentation Requirements

All contacts for SACOT services must be documented - a full daily service note is the minimum requirement. Documentation must meet all record and documentation requirements in the DMH/DD/SAS Records Management and Documentation Manual. Review policy and procedure manuals for language that demonstrates that all contacts with or on behalf of the recipient must be recorded in the service record. Review policy and procedure manuals and job descriptions for language demonstrating the SACOT provider will ensure service documentation is completed per Medicaid guidelines. Review policy and procedure manuals for language which addresses completion of required forms, transition and discharge planning.

a. Review service note for above requirements. The SACOT can document each intervention separately, for example, a service note for each of the following: two 1½ hour groups and 1 hour individual. Each service note must meet the stated requirements and all interventions for the date of services must be a minimum of 4 hours total.

The 60 day follow-up review should include a review of service records to verify that all components of each full service note are included in the documentation and to verify that contacts are documented. The SACOT provider may document each intervention separately. For example, there may be a service note for each of the following: two 1½ hour groups and 1 hour individual. Each service note must meet the stated requirements and the length of service for all interventions on the date of service must equal a minimum of 4 hours total. PCPs shall have all the required components and address plans for transition/discharge. Service notes should relate directly to the needs and goals identified in the recipients' PCPs.

b. Review in policy and procedure manuals, program descriptions, and other documentation for language demonstrating that the program intends that a discharge plan, which has been discussed with the recipient, will be included in each record. Review consumer medical records and other records to ensure that a discharge plan, which has been discussed with the recipient, is found in each medical record.